DOMINION ORTHOPAEDIC & SPINE

WELCOME TO OUR OFFICE

WE FIND THAT COMMUNICATION WITH OUR PATIENTS REGARDING OUR BUSINESS OFFICE POLICIES ASSISTS US IN PROVIDING YOU THE BEST SERVICE. THEREFORE WE HAVE PROVIDED A HIGHLIGHT OF SOME IMPORTANT POINTS.

- Please advise us if you change your address, phone number, place of employment, or insurance.
- You agree that you are financially responsible for any and all charges incurred in connection with your medical treatment at Dominion Orthopaedic & Spine. We will credit your account for any payments received from:

  (a) your valid health insurance plan, as approved by your plan; and
  (b) any secondary payment source that you have identified with our business office. You may have a balance due after such payment(s) are received, if any, for which you fully agree to guarantee payment and promptly pay your balance in full.

- If you have valid health insurance and wish to use as a payment source, **YOU MUST PRESENT YOUR INSURANCE CARD / IDENTIFICATION AT THE TIME OF SERVICE OR PRIOR TO YOUR APPOINTMENT.** You agree that you are financially responsible for any and all charges for services that are denied or not covered under your health insurance plan.
- It is your responsibility to obtain a referral from your primary care physician for services rendered in our office. Charges which are denied due to lack of a referral are your responsibility.
- Some insurers normally do not pay for supplies provided by our office. If we inform you that a supply prescribed by your physician will not be covered, we expect payment when you receive the supply. In the event that your insurance company is billed and does not remit payment, you will be billed for the supplies which are not paid.
- If you need to cancel or reschedule your appointment, you must do so at least 24 hours before your scheduled office appointment and 48 hours before your scheduled procedure.
- There is a $40.00 administrative fee for any forms (FMLA, Disability forms, etc) that are needed to be completed. Please allow a 5-7 business days for the forms to be completed.
- A fee of $35.00 will be added to your account for any check returned by your financial institution.

I have read the above business office policy statements. As a patient of Dominion Orthopaedic & Spine, I understand and accept all the terms herein.

_____ _____

Patient/Guardian Signature **Date**

DOMINION ORTHOPAEDIC & SPINE

New Patient Questionnaire/Nuevo Paciente Cuestionario

Date/Fecha:	**Patient Name**/ Nombre del paciente:		**DOB**/ Fecha de nacimiento:
Primary Care Physician/ Médico de atención primaria:		**Referred by**/ Referido por:	
VITALS:/Signos vitales:	**WEIGHT**/Peso:	**HEIGHT**/Estatura:	**Age**/ Edad:

Pregnancy/Embarazo **(circle one**/circule uno*)*:

Are you currently pregnant/Actualmente está embarazada? Yes No Unknown/Desconocido

Have you been treated by another physician in our practice/Alguna vez ha sido tratado por algún doctor en nuestra oficina**? (Please check box**/Por favor seleccione una casilla**):**

☐ Dr. John Foster III ☐ Dr. Nicole Forsythe ☐ Dr. William Sutlive ☐ Dr. Eric Steenlage ☐ Dr. Pinecca Patel ☐ Dr. Jeffrey Kovacic

Have any family members been treated by Dominion Orthopaedic & Spine/Algún miembro de su familia ha sido tratado por Dominion Orthopaedic & Spine **?**

☐ No Yes☐ _____

REASON FOR VISIT/Razon de su visita (Check all that apply/Seleccione alguna de las casillas)

Location	**Right**	**Left**	**Both**	**Location**	**Right**	**Left**	**Both**
Back/Espalda				Thigh/Muslo			
Neck/Cuello				Knee/Rodilla			
Shoulder/Hombro				Shin/Menton			
Elbow/Codo				Ankle/Robillo			
Wrist/Muñeca				Foot/Pie			
Hand/ Mano				Toe/Eedo del pie			
Finger/Dedo				Other/Otro:			
Hip/Cadera							

Date of Injury(Fecha del accidente)**:** _____

Is your injury work-related (su accidente estuvo relacionado con el trabajo)**?:** ☐Yes ☐ No

How did your injury occur/Como ocurrió el accidente**?:**_ _____

_____

_____

Please circle your dominant hand/Por favor seleccione su mano dominante**:** Right/Derecha Left/Izquierda

How SEVERE is your pain/Que tan severo es su dolor? **(Circle one**/circule uno**):** MILD/Poco MODERATE/Moderado SEVERE/Severo

Describe the ONSET of your pain/Describa el inicio de su dolor **(Select one**/Seleccione uno**):**

☐ GRADUAL/Gradual ☐ SUDDEN/Repentino

☐ GRADUAL FOLLOWING AN INCIDENT AT WORK/Gradual después del accidente de trabajo

☐ SUDDEN FOLLOWING AN INCIDENT AT WORK/Repentino después del accidente de trabajo

☐ SUDDEN FOLLOWING A MOTOR VEHICLE ACCIDENT/Repentino después del accidente automovilístico

☐ SUDDEN FOLLOWING A SLIP & FALL/Resbalón y caída

How long have you had your pain/ Por cuanto tiempo ha sentido malestar?

(Enter #/Escriba #**)**_____ **(Circle one**/Circule uno**)** HOURS/Horas DAYS/Días WEEKS/Semanas MONTHS/Meses YEARS/Años

Describe the COURSE of your pain/Describe el curso de su dolor **(Circle one**/circule uno**):**

INCREASING/Incrementando DECREASING/Decreciendo CONSTANT/Constante

Describe the PATTERN of your pain/describe el patron de su dolor **(Circle one**/circule uno**):**

INTERMITTENT/Intermitente PERSISTENT/Persistente

What DIAGNOSTIC tests have you had for this problem/Qué tipo de exámenes diagnósticos ha recibido para este problema**? (Circle one**/circule uno**)** ☐ MRI ☐ CT ☐ X-RAY Who ordered/Quien ordeno?: _____ Facility/Lugar: _____

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What TREATMENTS have you had for this problem/Que tipo de tratamiento ha recibido para este problema? **(Circle one**/circule uno)
NONE/Ninguno INJECTION/Inyección OCCUPATIONAL THERAPY/Terapia ocupacional PHYSICAL THERAPY/Terapia física
CHIROPRACTIC CARE/Quiropráctico (Dr. Name/nombre del doctor & Location/ locación_____)

ALLERGIES/Alergias
Please circle medication allergies and list reactions:/Por favor circule los medicamentos a los que es alérgico y explique cual es su reacción.

NONE/Ninguno	PENICILLIN/Penicilina	SULFA/Sulfamida	CODEINE/Codeína	IODINE IVP DYE/Contraste intravenosa
LATEX/Latex	ERYTHROMYCIN/Eritromicina	LEVAGUIN/Levaguin	DEMEROL/Demerol	IBUPROFEN/Ibuprofeno
OTHER/Otro			**REACTION/Reacción**:	

FAMILY HISTORY/Historia familiar: ☐ None/Ninguno

Complete all that applies/Complete todo lo que aplique

Medical Problem	**Family Member**	**Medical Problem**	**Family Member**
1. Heart Disease/Enfermedades del corazon		5. Kidney Problems/Insuficiencia renal	
2. Diabetes		6. Hypertension/Hipertensión	
3. Stroke/Infarto		7. High Cholesterol/Colesterol alto	
4. Bleeding problems/Hemorragias		8. Osteoporosis	

PAST MEDICAL HISTORY/Historial medico: ☐ None/Ninguno

Complete all that applies/Complete todo lo que aplique

HYPERTENSION/Hipertension	**ASTHMA**/Asma	**ANEMIC**/Anemia	**HIV**/HVI	**BLOOD CLOTS**/Coágulo de sangre
HIGH CHOLESTEROL/Alto colesterol	**PACEMAKER**/Marcapasos	**STROKE**/Infarto	**DIABETES**	**ULCERS**/Ulceras
HEPATITIS A B C	**ULCER(STOMACH)**/Ulcera en el estomago	**GOUT**	**CANCER** [type]	
RHEUMATOID ARTHRITIS/artritis reumatoide	**DEPRESSION**/Depresión	**RENAL INSUFFICIENCY**/Insuficiencia renal		
KIDNEY DISEASE/Enfermedad del riñon	**THYROID ISSUES**/Problema tiroides	**OTHER**/Otro:_____		

PAST SURGICAL HISTORY/Historial de cirugías anteriores: ☐ None/ ninguna

(LIST ALL/Listar todo)

SURGERY/Cirugía	**DATE**/Fecha	**HOSPITAL**
1.		
2.		
3.		
4.		

SOCIAL HISTORY/Historial social:

Tobacco/Tabaquismo: YES NO OCCASIONAL How often?/Frecuencia? _____
Alcohol/Alchoolismo: YES NO OCCASIONAL How often?/Frecuencia? _____
Drugs/Drogas: YES NO OCCASIONAL How often?/Frecuencia? _____

Please list your current medications/Por favor enliste su medicación actual: ☐ None/Ninguno

1.	6.	10.
2.	7.	11.
3.	8.	12.
4.	9.	13.

PHARMACY Name:/ Nombre de su farmacia _____ **Phone:** _____

Patient Signature/Firma del paciente: _____

DOMINION ORTHOPAEDIC & SPINE

PATIENT INFORMATION

Name/Nombre:	Date of Birth/Fecha de nacimiento:
Address/Direccion:	Social Security/Numero seguridad social:
City/Ciudad:	Sex/Sexo:
State/Estado: Zip:	Employer/Trabajador:
Home Phone/Teléfono casa#:	Emergency Contact/Contacto de emergencia#:
Work Phone/Teléfono trabajo#:	Emergency Phone/Numero de emergencia#:
Cell Phone#/ Teléfono cellular #:	Emergency Relationship/Emergencia Relación#:

GUARANTOR (RESPONSIBLE PARTY) INFORMATION IF DIFFERENT FROM PATIENT

Name/Nombre::	Date of Birth/fecha de nacimiento:
Address/Direccion:	Social Security/numero seguridad social:
City/Ciudad:	
State/Estado: Zip:	Employer/Empleador:
Home Phone/Teléfono casa#:	Employer Address/Dirección empleador:
Work Phone/Teléfono trabajo#:	Employer City/Ciudad empleador:
Cell Phone#:	Employer State/Estado empleador: Zip:

INSURANCE INFORMATION

Primary Insurance/Seguro:	Secondary Insurance/Seguro secundario:
ID/Policy/Claim#:	Certificate/ID#:
Group/Grupo #:	Group #:
Group Name/Nombre grupo:	Group Name:
Copay:	Copay:
Subscriber Name/Nombre suscritor:	Subscriber Name:

ADDITIONAL INFORMATION

Primary Care Physician/Doctor de cabeza:	Pharmacy Name/Nombre farmacia:
Phone/Numero:	Phone/Teléfono:
Fax:	Fax:
Address/Dirección:	Address/Dirección:
City/Ciudad:	City/Ciudad:
State/Estado: Zip:	State/Estado: Zip:
Complete information below, if applicable:	
Attorney Name/Nombre del abogado:	Adjuster Name/Nombre del ajustador:
Phone #/Numero:	Phone#:
Address/Dirección:	Fax#:
City/State/Zip:	Date of Injury/Dia del accidente:

Authorization To Pay Benefits To Physician: I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to myself or Dominion Orthopaedic & Spine when they accept assignment./Autorizo la liberación de cualquier información necesaria para uso del seguro medico. Tambien autorizo el pago a Dominion Orthopaedic por sus servicios asignados.

Authorization To Release Medical Information. I hereby authorize Dominion Orthopedic & Spine to release any information necessary for my course of treatment./Autorizo a Dominion Orthopaedic & Spine liberar cualquier información necesaria para mi tratamiento.

_____ _____

Signed (patient or parent if minor) **Date**

DOMINION ORTHOPAEDIC & SPINE

PATIENT HEALTH INFORMATION – RELEASE AUTHORIZATION

AUTORIZACION PARA LIBERAR LA INFORMACION MEDICA DEL PACIENTE

Your health and medical information is considered sensitive and private and is afforded protection under the law. However, there are circumstances when you may want someone other than yourself to pick up documents, x-rays or other items on your behalf./ Su información médica es importante, privada y protegida por la ley. Sin embargo, puede existir el caso en donde necesite de alguien además de usted para recoger o recibir sus documentos, rayos x o cualquier otro objeto a su nombre.

Please list the names of any individuals that you would like to access or retrieve personal health information, documents, or other items on your behalf:/ Por favor escriba el nombre de cualquier persona que le gustaría tuviera el poder de recibir su información medica u otra información a su nombre.

1. _____ Relation/relacion: _____

2. _____ Relation/relación: _____

3. _____ Relation/relación: _____

___ I decline to have anyone pick-up patient information on my behalf./ Me niego a que alguien reciba mi información.

I understand that authorizing disclosure of this health information is voluntary and I can refuse to sign this authorization. Any other use of this information without my written consent is prohibited. I further understand that I may revoke this consent (in writing) at any time except to the extent that action has been taken in reliance on it./ Entiendo que autorizar la liberación de mi información es voluntaria y me puedo negar a firmar esta autorización. Cualquier otro uso de esta información sin mi consentimiento es prohibido. También entiendo que en un futuro puedo retirar mi consentimiento en cualquier momento excepto cuando esta acción ya haya sido aplicada.

_____ _____

Signature of Patient or Legal Representative
Firma del paciente o representante legal

Date
Fecha

AUTHORIZATION TO OBTAIN MOTOR VEHICLE ACCIDENT REPORTS, INCIDENT REPORTS AND RECORDS ASSOCIATED WITH MY CLAIM

AUTORIZACION PARA LIBERAR EL REPORTE DEL ACCIDENTE VEHICULAR. REPORTES DE INCIDENTES Y LOS EXPEDIENTES ASOCIADOS CON MI CASO

I,_____*(patient full name/nombre completo)*, hereby authorize Dominion Orthopaedic & Spine and its affiliates (collectively, "Dominion") to obtain, on my behalf, any and all report(s), narrative(s) or other relevant Information, specifically, in connection with my personal injury claim that occurred on or around _____ *(date of incident/fecha del accidente)* further identified as a

_____ (patient write in type of incident/escriba el tipo de accidente), from any governmental agency, law firm, or other party in interest. I understand that Dominion Orthopaedic & Spine will promptly furnish a courtesy copy of any report(s) or information obtained on my behalf, at my request.

_____ _____

Signature of Patient or Legal Representative
Firma del paciente o representante legal

Date
fecha

DOMINION ORTHOPAEDIC & SPINE

EFFECTIVE DATE APRIL 1, 2003

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU. The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures, we will elaborate on the meaning and provide more specific examples, if you request. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive at the practice may be billed to and payment may be collected from you, an insurance company or a third party. For example: we may disclose your record to an insurance company, so that we can get paid for treating you.

For Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you at the practice or the hospital. For example, we may disclose medical information about you to people outside the practice who may be involved in your medical care, such as family members, clergy or other persons that are part of your care.

For Health Care Operations. We may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to run the practice and ensure that all of our patients receive quality care. We may also disclose information to doctors, nurses, technicians, medical students, and other practice personnel for review and learning purposes. For example, we may review your record to assist our quality improvement efforts.

WHO WILL FOLLOW THIS NOTICE. This notice describes our practice's policies and procedures and that of any health care professional authorized to enter information into your medical chart, any member of a volunteer group which we allow to help you, as well as all employees, staff and other practice personnel.

POLICY REGARDING THE PROTECTION OF PERSONAL INFORMATION. We create a record of the care and services you receive at the practice. We need this record in order to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the practice, whether made by practice personnel or by your personal doctor. The law requires us to: make sure that medical information that identifies you is kept private; give you this notice of our legal duties and privacy practices with respect to medical information about you; and to follow the terms of the notice that is currently in effect. Other ways we may use or disclose your protected healthcare information include: appointment reminders; as required by law; for health-related benefits and services; to individuals involved in your care or payment for your care; research; to avert a serious threat to health or safety; and for treatment alternatives. Other uses and disclosures of your personal information could include disclosure to, or for: coroners, medical examiners and funeral directors; health oversight activities; inmates; law enforcement; lawsuits and disputes; military and veterans; national security and intelligence activities; organ and tissue donation; protective services for the President and others; public health risks; and worker's compensation.

NOTICE OF INDIVIDUAL RIGHTS

You have the following rights regarding medical information we maintain about you:

Right to a Paper Copy of this Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. We may deny your request to inspect and copy in certain very limited circumstances.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by, or for, the practice. To request an amendment, your request must be made in writing and submitted to the Privacy Officer and you must provide a reason that supports your request. We may deny your request for an amendment.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. ***We are not required to agree to your request.*** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the Privacy Officer.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You must make your request in writing and you must specify how or where you wish to be contacted.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer.

CHANGES TO THIS NOTICE. We reserve the right to change this notice. We will post a copy of the current notice in the practice's waiting room.

COMPLAINTS. If you believe your privacy rights have been violated, you may file a complaint with the practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the practice, contact **[insert the name, title, and phone number of the contact person or office responsible for handling complaints]**. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

OTHER USES OF MEDICAL INFORMATION. Other uses and disclosures of medical information not covered by this notice or the laws that apply to use will be made only with your written authorization. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time.

If you have any questions about this notice or would like to receive a more detailed explanation, please contact our Privacy Officer.

[Practice Managers: If you choose to have patients or their personal representatives sign this Notice, please use the lines below. Otherwise, the lines below should be removed.]

I acknowledge by signing below that I have received the Notice of Privacy Practices and Notice of Individual Rights.

_____ _____

Patient or Patient's Personal Representative **Date**

DOMINION ORTHOPAEDIC & SPINE

PATIENT CONSENT FORM

PLEASE READ AND SIGN

I, the undersigned, hereby consent to the following treatment:

- Administration and performance of all treatments.
- Administration of any needed anesthetics.
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient.
- Use of prescribed medication.
- Performance of diagnostic procedures/tests and cultures.
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees.

I fully understand that this given in advance of any specific diagnosis or treatment.

I intend this consent to be continuing in nature even after specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I understand that **John I. Foster, III, M.D., FACS, Nicole E. Forsythe, M.D.** will include consent at satellite offices under common ownership.

I, the undersigned, authorize **John I. Foster, III, M.D., FACS, Nicole E. Forsythe, M.D.** to use and disclose my information for the purposes of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices.

A photocopy of this consent shall be considered as valid as the original.

MEDICARE PATIENTS: I authorize the release of medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to **John I. Foster, III, M.D., FACS, Nicole E. Forsythe, M.D.**

I acknowledge that I have been given the Notice of Privacy Practices of **Dominion Orthopaedic and Spine.** I understand that if I have questions or complaints that I should contact the Privacy Official.
PATIENT INITIAL:_____

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ _____

Patient(or Responsible Party) Signature Date

DOMINION ORTHOPAEDIC & SPINE

PATIENT PAIN MANAGEMENT

It is our goal to manage our patient's pain in the healthiest manner. Dominion Orthopaedic and Spine policy regarding pain medicine is as follows:

- I understand that there are potential side effect(s) / risk(s) associated with taking narcotics such as opiates, cocaine derivatives in Schedule II drugs or benzodiazepines (collectively "controlled substances"), including:
  - Addiction
  - Tolerance
  - Dependence
  - Increased Pain
  - Respiratory depression
  - Constipation
  - Loss of libido
  - Sedation
  - Change of menstrual patterns
  - Hormonal changes necessitating the consultation of an endocrinologist
  - Risks to unborn children
  - Changes in sleep pattern
  - Potential of lethal interaction with other medications, including alcohol
  - Stopping the medication(s) may cause withdrawal

- I will immediately notify Dominion Orthopaedic and Spine if I experience any of the above side effects / risks.

- I understand that I cannot, under any circumstances, consume alcohol while taking these controlled substances.

- I understand that I cannot, under any circumstances, consume any illicit or borrowed controlled medication.

- I understand that I am fully responsible for managing and the safekeeping my medication. If my medication or prescription is lost or stolen, a replacement will not be given. Prior to the next refill, if any, a police report must be obtained and a copy provided to Dominion Orthopaedic and Spine. I will not give, sell, or divert my medication to anyone else for any reason.

- Nonsurgical patients will be given narcotics for 2 to 3 weeks after the onset of the acute phase of their injury or illness. Then non-narcotic measures will be implemented for pain control.

- Patients will be given strong pain medication when scheduling their surgery. This prescription will be for their use immediately following their surgery. This allows patients the convenience of having their pain medication filled, and readily available to them when returning home after surgery. It will be the patient's responsibility not to lose or use this prescription before surgery. No exceptions will be made if this prescription is lost or used, for writing any additional prescriptions.

- If pain continues, a lesser strength pain medication will be prescribed. These types of pain medications will be given for 2 to 6 weeks depending on the severity of the surgery.

- Following these 6 weeks, no other narcotic pain medication will be given. Measures used to decrease pain will include: Physical therapy, icing, rest, NSAIDs, and muscle relaxants.

DOMINION ORTHOPAEDIC & SPINE

PATIENT PAIN MANAGEMENT

- If pain persists following the above, patients will be referred to pain management specialist.
- If we determine our patient is obtaining narcotics elsewhere, the patient will not receive any future pain prescriptions.
- No narcotics will be called in by this practice. NARCOTIC PRESCRIPTIONS MUST BE OBTAINED AT THE TIME YOU ARE SEEING DR. FOSTER AND DR FORSYTHE.

DOMINION ORTHOPAEDIC AND SPINE believes the above policy is only in the best interest of all our patients. Each patient's request will be evaluated individually and professionally. It is our wish that patients do not become addicted to narcotic pain medication.

I, _____, give Dominion Orthopaedic and Spine permission to research, discuss and fully disclose my narcotic history (including information entered and obtained via the Georgia Prescription Drug Monitoring Program "GA PDMP" maintained by the Georgia Department of Public Health (404) 657-2700) with other physicians, pharmacies and my health insurer(s) involved with my medical care and payment of same.

I acknowledge, fully understand and agree to strictly adhere to all of the policies and directives set forth herein.

_____ _____

Patient Signature **Date**

DOMINION ORTHOPAEDIC & SPINE

MEDICAL RELEASE AUTHORIZATION

You are authorized and directed to furnish any and all information requested pertaining to my medical care and treatment to:

Dominion Orthopaedic and Spine
John I. Foster, III, M.D., FACS
Nicole E. Forsythe, M.D.

5555 Peachtree Dunwoody Road
Suite 215
Atlanta, GA 30342
Phone: (770)455-4009
Fax: (770)455-4065

This authorization includes furnishing of the originals or copies of all charts, summaries, test results and all other written memoranda or data including x-rays and photographs.

This_____day of_____, _____.

Patient Name:

Patient's Signature:_____

Date of Birth:

Today's Date: _____

DOMINION ORTHOPAEDIC & SPINE

CANCELLATION & NO SHOW POLICY

As our goal is to meet the needs of our patients, we will make every effort to schedule your appointments as efficiently as possible. In return, ***it is your responsibility to make every effort to keep your scheduled appointments and to arrive promptly at the time instructed.***

However, we realize that unanticipated events can occur and may prevent you from keeping your appointment. In fairness and consideration to the other patients that need to be seen as soon as possible, we hereby request that you notify our office immediately when you realize you will not be keeping your appointment.

If you need to cancel or reschedule your appointment, you must do so at least ***24 hours before your scheduled office appointment and 48 hours before your scheduled procedure*** to avoid paying a $50.00 fee. If you are scheduled for a surgery or a procedure, there is a $250.00 fee. This fee is **not** covered by your medical insurance or Worker's Compensation benefits. In an effort to see patients promptly at the scheduled time, therefore, this notification of 24 or 48 hours is necessary so that we may schedule other patients needing immediate appointments.

The cancellation/rescheduling fee must be paid on or before your next scheduled appointment. Thank you for your attention to this matter.

Worker's Compensation patients, please note that we will need to notify your adjustor and/or Nurse Case Manager in the event that you cancel within 48 hours of your scheduled procedure.

I hereby acknowledge that I have read and understand the above cancellation and no show policy and that I agree to abide by these guidelines.

_____ _____

Patient Signature **Date**